Executive Office of Health and Human Services

Common Intake Application for MassHealth and Other Benefits
Instruction Page

Please read this Instruction Page before you fill out the application.

Dear Applicant:

The Executive Office of Health and Human Services (EOHHS) is the agency that oversees the state's health and human services. This application is specifically for MassHealth, the Children's Medical Security Plan (CMSP), and Healthy Start. It is also for providing EOHHS with information to be used to determine low-income patient status for provider payments from the Uncompensated Care Pool. MassHealth gives health-care coverage and helps pay for health-insurance premiums for families, children, and individuals of any age. Your eligibility and the kind of coverage you get depends on your family size, income, immigration status, and, in some cases, your assets, employment status, and other health insurance you may have. **You will be given the most complete coverage that you qualify for**.

Who can use this application?

Generally, this application is for people who live in Massachusetts and are **not** living in a nursing home. If this application is not for you, call 1-888-665-9993 (TTY: 1-888-665-9997 for people with partial or total hearing loss) to find out if there is another application you should use for these programs.

Do you want to use this electronic application?

This application is designed for your use with the help of certain hospitals and community health centers that will forward your application information to EOHHS electronically. Because the information you give in this application will be forwarded to EOHHS electronically, it is called an electronic application. Instead of this electronic application, you can choose to apply for the four programs listed above by using a paper application called the MassHealth Medical Benefit Request (MBR), which is generally for families and persons under age 65, or the Senior Medical Benefit Request (SMBR) which is generally for seniors. The hospital or the community health center can help you choose which one is right for you.

When deciding whether to use this electronic application or the MBR or SMBR, please note the following:

- If you decide to use this electronic application, the information will be stored by EOHHS in its common intake application system. The information can then be accessed and used by other EOHHS programs if you apply for other EOHHS programs electronically through the common intake application system. If you do not want your information stored for use when applying for other EOHHS programs, do not fill out this electronic application. Instead, fill out the MBR or SMBR.

- If you use this electronic application, the hospital or community health center helping you will get copies of the eligibility notices that MassHealth will send to you. If you do not want them to get such information, do not fill out this electronic application. Instead, fill out the MBR or SMBR. If you want the hospital or community health center to get such information, you must fill out the MassHealth Virtual Gateway Permission to Share Information (PSI) Form that is enclosed with this application.

- Your eligibility date will be determined by the date MassHealth gets an MBR or SMBR in the mail or gets this electronic application electronically from the hospital or community health center that is helping you. If you take this electronic application home to fill out and send back to the hospital or community health center to forward electronically to MassHealth, your eligibility date may be later than if you took the MBR or SMBR home and sent it to MassHealth directly following the mailing directions in the MBR or SMBR.

The hospital or community health center will give you the application package that is right for you and/or your family, or if you want to call MassHealth to get this information, call at 1-800-841-2900 (TTY: 1-800-497-4648 for people with partial or total hearing loss).

How to complete the application.
Please read the MassHealth Member Booklet or the MassHealth and You Guide carefully before you fill out the application. Keep the booklet. It may answer questions you have later.

- List only one family group, which can be you, your spouse, any children under age 19, parents, stepparents, or adoptive parents who are all living together. If there are no parents living at home, a family group may be siblings under age 19, or children under age 19 and an adult related by blood, adoption, or marriage, or a spouse or former spouse of one of those relatives who are all living together. A family group can also be an individual or a married couple who are living together with no children. If you are a married couple with no children, then list only you and your spouse.

- Sign and date the application. The head of household, all applicants aged 18 or older, and all parents of any age who have children living with them must sign.

- Send proof of all income, assets (if applicable), and immigration status (if not a U.S. citizen).

- Complete the **Asset Supplement A** if you are aged 65 or older, or if you are a member of a married couple with one person aged 65 or over, or if you are any age and receiving long-term-care services at home.

- Complete the **Senior Supplement B** if you are aged 65 or older, or if you are a member of a married couple and one spouse is under the age of 65, or if you are receiving long-term-care services at home.

- Complete the **Absent Parent Supplement C** if anyone under age 19 in the household has a parent who does not live in the household.

- Complete the **Personal-Care-Attendant Supplement** if anyone aged 65 or older wants or needs personal-care-attendant services at home.

The information you give us is kept confidential to the extent required by state and federal laws.

Executive Office of Health and Human Services

MassHealth Virtual Gateway
Permission to Share Information (PSI) Form

Section 1: Name of MassHealth Applicant

Permission is given for MassHealth and its representatives to share information listed in **Section 2** about:

Name of applicant whose information is to be shared		Address	
Date of birth / /	Daytime telephone number ( )	Evening telephone number ( )	Social security number

with the person or organization listed in **Section 3**.

Please Note: The applicant's social security number is required if one has been issued, unless he or she is only applying for MassHealth Limited, Children's Medical Security Plan (CMSP), Healthy Start, or Uncompensated Care Pool benefits.

Section 2: Information You Want to Be Shared

Please read carefully.

I am giving MassHealth permission to share eligibility notices and information about eligibility for, and access to, MassHealth benefits with the person or organization listed in **Section 3**. (This means that you want the person or organization in **Section 3** to be able to contact MassHealth to get eligibility information and copies of your eligibility notices.)

Please Note: Eligibility notices include information about all members of a household. A separate PSI Form must be submitted and signed by each member of your household who is 18 years of age or older. If we do not get forms signed by each member or your household who is 18 years of age or older, we will not be able to honor your request.

Section 3: Whom Do You Want Us to Share Information With?

List the name of **ONLY ONE person or organization** in this section. You must fill out another PSI Form if you want to name more than one person or organization.

MassHealth may share the information listed in **Section 2** with:

Name of person or organization:	
In care of (name of person in organization to whom mail should be sent):	
Address:	
Telephone number: ( )	Fax number: ( )

Section 4: Why Do You Want to Share Your information?

Tell us why you want to share the information listed in **Section 2**. If you do not want to list reasons, write: "at my request." If you leave this section blank, we will assume you meant "at my request."

I am giving MassHealth permission to share the information listed in Section 2 because: At my request

Section 5: End of Permission

This Permission to Share Information is good until: One year from date of application

Section 6: Signature

I understand that:

- when the person or organization named in **Section 3** gets this information from MassHealth, that person or organization may be able to share it with others without my permission. If they do so, federal and state privacy laws may not protect the information;
- I may cancel this permission at any time by sending a letter to:
  MassHealth
  Privacy and Security Office
  600 Washington Street
  Boston, MA 02111;
- if I cancel this permission, MassHealth cannot take back any information that it shared when it had my permission to do so;
- if I do not give MassHealth permission to share information, or if I cancel my permission to share information with the person or organization named in **Section 3**, my MassHealth benefits will not be affected in any way; and
- in certain circumstances, MassHealth may not honor my request to share information.

Signature of applicant:_____ Date: _____

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Common Intake Application for MassHealth and Other Benefits

Head of Household Information

First name	Middle name	Last name
▶ Is this person applying? ☐ yes ☐ no	Gender ☐ Male ☐ Female	Date of birth / /

Head of Household Address

Street address	Unit	▶ Homeless? ☐ yes ☐ no
City	State	Zip code/postal code

Head of Household Mailing Address

▶ Does the household have a different mailing address? ☐ yes ☐ no ***(If yes, please fill out this section.)***

PO Box	Street address	Unit
City	State	Zip code/postal code

▶ If age less than 19, is this person an Alaska Native or a member of a federally recognized American Indian tribe?* ☐ yes ☐ no

▶ Does this individual need long-term-care services at home? ☐ yes ☐ no

If you are not a U.S. citizen, you need to answer the next two questions.

▶ If aged 18 or older, is this person on active duty in the United States Armed Forces? ☐ yes ☐ no

▶ If aged 18 or older, is this person a veteran of the United States Armed Forces with an honorable discharge or did this person serve under U.S. command during World War II or Vietnam? ☐ yes ☐ no

Social security number**	▶ If applying, is this person a U.S. citizen? ☐ yes ☐ no	
Ethnicity (optional)	Ethnicity type (optional)	Race (optional)

Other Family Members (List spouse first if living with Head of Houshold)

First name	Middle name	Last name
Relationship to head of household	▶ Is this person applying? ☐ yes ☐ no	
Gender ☐ Male ☐ Female / Date of birth / /	▶ If age less than 19, is this person an Alaska Native or a member of a federally recognized American Indian tribe?* ☐ yes ☐ no	

▶ Does this individual need long-term-care services at home? ☐ yes ☐ no

If you are not a U.S. citizen, you need to answer the next two questions.

▶ If aged 18 or older, is this person on active duty in the United States Armed Forces? ☐ yes ☐ no

▶ If aged 18 or older, is this person a veteran of the United States Armed Forces with an honorable discharge or did this person serve under U.S. command during World War II or Vietnam? ☐ yes ☐ no

Social security number**	▶ If applying, is this person a U.S. citizen? ☐ yes ☐ no	
Ethnicity (optional)	Ethnicity type (optional)	Race (optional)

* Family members under the age of 19 who are Alaska Natives or members of a federally recognized American Indian tribe who get MassHealth Family Assistance may not have to pay any premiums for this coverage.

** Required, if one has been issued and this person is applying for MassHealth, except for MassHealth Limited, CMSP, Healthy Start, or the Uncompensated Care Pool.

Other Family Members (cont.)

First name | Middle name | Last name

Relationship to head of household | ▶ Is this person applying? ☐ yes ☐ no

Gender ☐ Male ☐ Female | Date of birth / / | ▶ If age less than 19, is this person an Alaska Native or a member of a federally recognized American Indian tribe?* ☐ yes ☐ no

▶ Does this individual need long-term-care services at home? ☐ yes ☐ no

If you are not a U.S. citizen, you need to answer the next two questions.

▶ If aged 18 or older, is this person on active duty in the United States Armed Forces? ☐ yes ☐ no

▶ If aged 18 or older, is this person a veteran of the United States Armed Forces with an honorable discharge or did this person serve under U.S. command during World War II or Vietnam? ☐ yes ☐ no

Social security number** | ▶ If applying, is this person a U.S. citizen? ☐ yes ☐ no

Ethnicity (optional) | Ethnicity type (optional) | Race (optional)

First name | Middle name | Last name

Relationship to head of household | ▶ Is this person applying? ☐ yes ☐ no

Gender ☐ Male ☐ Female | Date of birth / / | ▶ If age less than 19, is this person an Alaska Native or a member of a federally recognized American Indian tribe?* ☐ yes ☐ no

▶ Does this individual need long-term-care services at home? ☐ yes ☐ no

If you are not a U.S. citizen, you need to answer the next two questions.

▶ If aged 18 or older, is this person on active duty in the United States Armed Forces? ☐ yes ☐ no

▶ If aged 18 or older, is this person a veteran of the United States Armed Forces with an honorable discharge or did this person serve under U.S. command during World War II or Vietnam? ☐ yes ☐ no

Social security number** | ▶ If applying, is this person a U.S. citizen? ☐ yes ☐ no

Ethnicity (optional) | Ethnicity type (optional) | Race (optional)

First name | Middle name | Last name

Relationship to head of household | ▶ Is this person applying? ☐ yes ☐ no

Gender ☐ Male ☐ Female | Date of birth / / | ▶ If age less than 19, is this person an Alaska Native or a member of a federally recognized American Indian tribe?* ☐ yes ☐ no

▶ Does this individual need long-term-care services at home? ☐ yes ☐ no

If you are not a U.S. citizen, you need to answer the next two questions.

▶ If aged 18 or older, is this person on active duty in the United States Armed Forces? ☐ yes ☐ no

▶ If aged 18 or older, is this person a veteran of the United States Armed Forces with an honorable discharge or did this person serve under U.S. command during World War II or Vietnam? ☐ yes ☐ no

Social security number** | ▶ If applying, is this person a U.S. citizen? ☐ yes ☐ no

Ethnicity (optional) | Ethnicity type (optional) | Race (optional)

* Family members under the age of 19 who are Alaska Natives or members of a federally recognized American Indian tribe who get MassHealth Family Assistance may not have to pay any premiums for this coverage.

** Required, if one has been issued and this person is applying for MassHealth, except for MassHealth Limited, CMSP, Healthy Start, or the Uncompensated Care Pool.

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Additional Personal Information

▶ Is anyone in the household **pregnant**? ☐ yes ☐ no ***(If yes, please fill out this section.)***

Pregnant member	Number expected	Due date / /

▶ Is anyone in the household applying because of an **accident, injury, or illness caused by someone else**? ☐ yes ☐ no
(If yes, please fill out this section.)

▶ Person applying because of an accident, injury, or illness

▶ Lawsuit or claim has been filed? ☐ yes ☐ no

▶ Is person covered by other insurance (not health insurance)? ☐ yes ☐ no

▶ Is anyone in this household **injured, ill, or disabled?** ☐ yes ☐ no ***(If yes, please fill out this section.)***

1. Person with a disability, illness, or injury

▶ Has the condition lasted or expected to last at least 12 months? ☐ yes ☐ no

▶ Receive Social Security disability? ☐ yes ☐ no

▶ Ever received Supplemental Security Income? ☐ yes ☐ no

▶ Legally blind? ☐ yes ☐ no
☒ If blind, **send certificate of blindness**.

2. Person with a disability, illness, or injury

▶ Has the condition lasted or expected to last at least 12 months? ☐ yes ☐ no

▶ Receive Social Security disability? ☐ yes ☐ no

▶ Ever received Supplemental Security Income? ☐ yes ☐ no

▶ Legally blind? ☐ yes ☐ no
☒ If blind, **send certificate of blindness**.

▶ Are you (or any family member aged 19 or older) unemployed, only working from time to time, or retired? ☐ yes ☐ no
(If yes, please fill out this section.)

Person who is unemployed, only working from time to time, or retired

▶ College student 75% or more of the time? ☐ yes ☐ no

▶ Has worked in past 12 months? ☐ yes ☐ no

▶ If worked from time to time, how much earned in the past 12 months (before taxes and deductions)? ☐ yes ☐ no

▶ Is anyone in the household **HIV positive** (optional)? ☐ yes ☐ no
MassHealth may give benefits to people who are HIV positive who might not otherwise be eligible.

HIV-positive member(s) (optional)

☒ **Send proof** of your HIV-positive status. While we wait for proof of your HIV-positive status, you may get benefits for up to 60 days if you verify your income.

Household Contact Information

Head of household name	Day telephone ( )	Evening telephone ( )	Spoken language	Written language

Immigration Status Information

If you are a U.S. citizen, you DO NOT have to fill out this page.

The citizenship status of parents does not affect the eligibility of their children.

If you already answered "yes" to any of the following 2 questions (A and B) or to the active duty or veteran questions on pages 1 or 2 of this application, **you do not have to fill out this page. Please go to the next page, "Salary/Wage Income Information."**

If you answered "no" to the veteran questions on pages 3 or 4 and answered "no" to the following 2 questions (A or B), you will need to fill out the immigration status chart below. If you do not fit any status, you may apply for MassHealth Limited, CMSP, Healthy Start, or Uncompensated Care Pool.

A. ▶ Is anyone in the household a spouse, widow(er), or a dependent of someone that is on active duty or of a veteran of the United States Armed Forces with an honorable discharge or who served under U.S. command during World War II or in Vietnam? ☐ yes ☐ no

B. ▶ Is anyone in the household a domestic abuse victim not living with the abuser? ☐ yes ☐ no

Please fill out the chart below for each member of the family who is **not** a U.S. citizen and who is applying for MassHealth. List ***all*** statuses that have applied to each person since that person entered the U.S.

Note: Family members who only want to get one or more of the following: MassHealth Limited, CMSP, Healthy Start, or Uncompensated Care Pool, do not have to give us a social security number. We will not match their names with any other agency including the Department of Homeland Security (DHS). You do not need to send proof of or list below their immigration status, but you must list their names below and answer "Yes" to "Is this person applying only for MassHealth Limited, CMSP, Healthy Start, or Uncompensated Care Pool?" MassHealth Limited pays for emergency services only. See the MassHealth Member Booklet or the MassHealth and You Guide for more information.

Use the following statuses:
Amerasian admitted pursuant to Section 584 of Public Law 100-202, Granted Asylum, Granted Parole, Conditional Entrant, Person Residing under Color of Law (PRUCOL), Deportation Withheld, Refugee, Legal Permanent Resident, Temporary Visa/Other, No Information, Cuban/Haitian Entrant, Native American with at least 50 % American Indian Blood Born in Canada, Victim of Severe Forms of Trafficking.

Member name	Status(es)	Date status awarded	U.S. entry date	▶ Is this person applying only for MassHealth Limited, CMSP, Healthy Start, or Uncompensated Care Pool?
		/ /	/ /	☐ yes ☐ no
		/ /	/ /	☐ yes ☐ no
		/ /	/ /	☐ yes ☐ no
		/ /	/ /	☐ yes ☐ no
		/ /	/ /	☐ yes ☐ no

✉ **Send copies** of both sides of all immigration cards (or other documents that show immigration status). ***See the last page of this application for a list of acceptable immigration verifications.***

Salary/Wage Income Information

▶ Does anyone in the household currently have salary/wage income (including self-employment)? ☐ yes ☐ no
(If yes, please fill out the section below.)

▶ Who has salary/wage income?	Employer name	Employer telephone number ( )

▶ Does this employer offer health insurance? ☐ yes ☐ no
We may be able to help you buy health insurance from your current employer.

Employer address

Street address			Unit
City	State	Zip code/postal code	Country

Wage type:
☐ wages ☐ self-employment ☐ student earnings ☐ day labor
☐ seasonal employment ☐ sheltered workshop ☐ other

▶ If wage type is student earnings, is assistance insured or funded by the government (such as college or work study)? ☐ yes ☐ no	▶ If wage type is student earnings, is assistance for a disabled person through a grant-funded program for the handicapped? ☐ yes ☐ no

▶ Is this job full-time? ☐ yes ☐ no	Pay period ☐ weekly ☐ bi-weekly (every two weeks) ☐ quarterly ☐ annually ☐ monthly ☐ semi-monthly (twice per month) ☐ one-time

Income amount (before deductions) for pay period listed above $	Number of hours worked per week	Start date of current salary for this job / /

▶ Who has salary/wage income?	Employer name	Employer telephone number ( )

▶ Does this employer offer health insurance?
We may be able to help you buy health insurance from your current employer.

Employer address

Street address			Unit
City	State	Zip code/postal code	Country

Wage type:
☐ wages ☐ self-employment ☐ student earnings ☐ day labor
☐ seasonal employment ☐ sheltered workshop ☐ other

▶ If wage type is student earnings, is assistance insured or funded by the government (such as college or work study) ☐ yes ☐ no	▶ If wage type is student earnings, is assistance for a disabled person through a grant-funded program for the handicapped? ☐ yes ☐ no

▶ Is this job full-time? ☐ yes ☐ no	Pay period ☐ weekly ☐ bi-weekly (every two weeks) ☐ quarterly ☐ annually ☐ monthly ☐ semi-monthly (twice per month) ☐ one-time

Income amount (before deductions) for pay period listed above $	Number of hours worked per week

Income amount (before deductions) for pay period listed above $	Number of hours worked per week	Start date of current salary for this job / /

✉ **Send proof** of wage income, like a copy of two recent pay stubs. If self-employed, send a copy of your most recent federal tax return.

Absent Parent Employer Information

Is there an absent parent not living in the household who is employed (including self-employment)? ☐ yes ☐ no
(If yes, please fill out this section.)

Who is employed?

Employer name	Employer telephone number ( )
Employer address	Zip code/postal code

Does this employer offer health insurance? ☐ yes ☐ no

Other Income Information

Income Types - Annuities, veterans' benefits, workers' compensation, social security, unemployment compensation, pensions, dividends or interest, trusts, retirement, SSI, roomer/boarder income, alimony, railroad retirement.

Does anyone in the household have other income? ☐ yes ☐ no ***(If yes, please fill out this section.)***

Who has other income?	Source of income (see types above)

If income type is education assistance, is the undergraduate grant or loan funded or insured by the government? ☐ yes ☐ no

Other income description

Payment period:	Amount of other income (before deductions)
☐ weekly ☐ bi-weekly (every two weeks) ☐ semi-monthly (twice per month) ☐ monthly ☐ quarterly ☐ annually ☐ one-time	$

✉ **Send proof** of other income.

Rental Income

Do you or your spouse have any rental income?

You ☐ yes ☐ no	Your spouse ☐ yes ☐ no

If yes, fill out this section.

Is rental income shared? ☐ yes ☐ no

Who shares the rental income? (list names)

What type of real estate is owned? (please describe, 2-family, 3-family, etc.)

Where is the real estate located?

Street	City	State	Zip code/postal code

Is this property owner-occupied? ☐ yes ☐ no

✉ **Send proof** of this income. ***See verification list at the end of application.***

Medicare Information

▶ Do you or any family member who is applying get Medicare? ☐ yes ☐ no ***(If yes, please fill out this section.)***

Name of person receiving Medicare	Medicare claim number
Name of person receiving Medicare	Medicare claim number

Medical Insurance Information

▶ Is anyone in the household covered by a medical insurance policy (other than Medicare)? ☐ yes ☐ no
(If yes, please fill out this section. If no, please go to the next section.) If you or any family member has health insurance, you may still be able to get MassHealth. Health insurance can be from an employer, an absent parent, a union, a school, or Medicare supplemental insurance, like Medex.

Insurance company name	Policyholder name
Name(s) of household members covered by this insurance policy	
Name of employer/union (or other source providing this insurance policy)	

Policy number	Group number	Policy start date / /

Policy type	Contribution period	Policyholder contribution
☐ individual ☐ couple (two adults) ☐ family ☐ dual (usually for one adult and one child)	☐ weekly ☐ quarterly ☐ monthly ☐ annually	$

▶ Did anyone in the household, including absent parents, have a job within the last six months that offered health insurance? ☐ yes ☐ no

(If yes, please fill out this section.) We may be able to help you buy health insurance from your former employer.

▶ Who left the job that offered health insurance?	Former employer name
Employer address	Zip code/postal code

Asset Supplement A

This supplement is only for individuals aged 65 or older, married couples with at least one spouse aged 65 or older, or individuals of any age getting or applying for long-term-care services at home.

Assets

Do you and/or spouse have any assets like bank accounts, life insurance, or other types of assets? ☐ yes ☐ no

If yes, complete this supplement and provide verifications. A complete list of acceptable verifications is attached to the last page of this application.

If no, go to Senior Supplement B.

List all assets below in each section. Include open accounts and assets that were closed or sold within the past 3 months.

Bank Accounts

Includes bank accounts, certificates of deposit, checking, savings, credit union, NOW, money market accounts, individual retirement accounts (IRAs), Keogh, and pension funds.

Name on account		Name of bank/institution	
Account number		Account type	Account co-owned? ☐ yes ☐ no
Current balance	☐ Account open ☐ Account closed	Date account closed / /	Amount on date account closed
Name on account		Name of bank/institution	
Account number		Account type	Account co-owned? ☐ yes ☐ no
Current balance	☐ Account open ☐ Account closed	Date account closed / /	Amount on date account closed
Name on account		Name of bank/institution	
Account number		Account type	Account co-owned? ☐ yes ☐ no
Current balance	☐ Account open ☐ Account closed	Date account closed / /	Amount on date account closed
Name on account		Name of bank/institution	
Account number		Account type	Account co-owned? ☐ yes ☐ no
Current balance	☐ Account open ☐ Account closed	Date account closed / /	Amount on date account closed

✉ **Send a copy** of your passbooks updated within 45 days and/or a copy of your current bank account statements.

Life Insurance

Owner(s) name(s)	Insurance company	Policy number	Face value	Cash surrender value

✉ **Send a copy** of the first page of all life-insurance policies. If total face value of all policies exceeds $1500 per person, also send a letter from the insurance company showing the current cash-surrender value (for all policies except term policies.)

Securities/Other

List securities, stocks, bonds, savings bonds, mutual funds, assets held in safe deposit boxes, cash not in a bank, other.

Select type from above	Owner(s) name(s)	Company name	Account number	Current value	If now closed, date closed	Joint asset
					/ /	☐ yes ☐ no
					/ /	☐ yes ☐ no
					/ /	☐ yes ☐ no

✉ **Send proof** of current value (except cash).

Annuities

List below any annuities that you or your spouse own.

Owner(s) name(s)	Name of institution issuing the annuity	Account number	If closed, date closed.
			/ /
			/ /

✉ **Send a copy** of the contract. For each annuity owned, send proof from the annuity company of the full value of the annuity less any penalties and fees if it can be cashed in.

Real Estate

List any real estate, including your primary residence that you or your spouse has a legal interest in.

Owner(s) name(s)	Real estate address	Type of property	Is this property generating income?	Has this property been sold within the past 3 months? If yes, date sold.
			☐ yes ☐ no	☐ yes ☐ no / /
			☐ yes ☐ no	☐ yes ☐ no / /
			☐ yes ☐ no	☐ yes ☐ no / /

✉ **Send a copy** of the deed(s), current tax bill(s), and proof of amount owned.

Vehicles/Mobile Homes

List below any vehicle you and your spouse own. Include cars, trucks, recreational vehicles, mobile homes, boats, or any other kind of vehicle.

Owner(s) name(s)	Type of vehicle	Year/make/model	Fair-market value	Amount owed	If vehicle sold, date sold.
					/ /
					/ /

✉ **Send a copy** of the registration for each vehicle, and proof of the outstanding loan balance. For mobile homes, send a copy of the bill of sale.

Trusts

Are you or your spouse the grantor/donor, trustee, or beneficiary of any trusts? If yes, complete the section below.

Trust name	Revocable?	Current trust principal	Trustee(s)	Grantor(s)/ donor(s)	Beneficiaries	If closed, date closed.
	☐ yes ☐ no					/ /
	☐ yes ☐ no					/ /

✉ **Send a copy** of the trust document(s) showing financial activity and the schedule of beneficiaries.

Senior Supplement B

For persons aged 65 or over, persons of any age who require long-term-care services at home, and persons who lost Supplemental Security Income (SSI) benefits.

Previous Medical Bills

▶ Does anyone in the household have bills for medical services received in the last 3 months?	
You ☐ yes ☐ no	Your spouse ☐ yes ☐ no
▶ Do you and /or your spouse want to apply for MassHealth for that time period?	
You ☐ yes ☐ no	Your spouse ☐ yes ☐ no
▶ If yes, what is the earliest date you and your spouse needs MassHealth? (List date below.)	
You / /	Your spouse / /

Previous Assistance

▶ Have you and/or your spouse ever received Supplemental Security Income (SSI)?	
You ☐ yes ☐ no	Your spouse ☐ yes ☐ no
▶ When did you and/or your spouse last get SSI?	
You / /	Your spouse / /

▶ Living arrangement (check one):

☐ live in own home ☐ share expenses with another/others ☐ live in someone else's home

☐ live in a rest home ☐ live in an assisted-living facility

Hospital or Nursing Facility Information

▶ Do you or your spouse currently reside in a hospital, nursing home, or other institution?			
You ☐ yes ☐ no	Your spouse ☐ yes ☐ no		
▶ If yes, list the name of the facility.			
Facility name			
Facility address	City	State	Zip code

Executive Office of Health and Human Services

Common Intake Application for MassHealth and Other Benefits
Absent Parent Supplement C

Absent Parent

Does anyone under 19 in the household have a parent who does not live in the household? ☐ yes ☐ no

(If "yes", go to "Assignment of Rights" below (Section A). If "no", you do not need to read or fill out the absent parent sections (Sections A, B, C, or D).)

Assignment of Rights – Section A

To get MassHealth for ***you and a child who is living with you***, you must cooperate with the Child Support Enforcement Division of the Massachusetts Department of Revenue (DOR) to establish paternity and enforce a medical support order, unless you have Good Cause not to cooperate. You must also assign your rights for medical support to MassHealth. Cooperation means that you may have to give information about the identity, location, and employment of the absent parent, appear for appointments with DOR staff and the Court, submit to paternity testing, give information, and take any other action necessary to help DOR in establishing paternity, and establishing, changing, or enforcing a child medical support order. Good cause is a legal term that means if you cooperated by giving us information about the absent parent, it would not be in the best interests of the child for any of the reasons listed on the next page in the Good Cause questions in Section B. If you think that you have Good Cause for not cooperating, fill out the Good Cause questions and do not fill out Absent Parent Information in Section C.

If you do not want to make a Good Cause claim, and you do not cooperate by filling out the Absent Parent information in Section C, your MassHealth eligibility could be affected.

To get MassHealth ***only for the child who is living with you and not for yourself***, you do not have to cooperate with DOR, assign your rights for medical support to MassHealth, or give information about the absent parent. Also, if a ***pregnant*** family member is applying for benefits for an unborn child, you do not need to give us information about the absent parent of the unborn child at this time. This means that you do not have to fill out the Good Cause questions or the Absent Parent information for that unborn child in Sections B, C, or D. Please read the next paragraph about child-support-enforcement services.

Even if you are applying for MassHealth only for the child who is living with you, you can ask for child-support-enforcement services if you want help getting the absent parent to pay for health insurance or child support for the child. To do this, you can call DOR at 1-800-332-2733, or go to www.mass.gov/dor and click on "Child Support." The child's MassHealth coverage will not be affected if you choose to ask for these services or not. If you ask for these services, you will have to cooperate with DOR.

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Absent Parent Supplement C

Please read Section A on the previous page before you fill out Sections B, C, and D below.

Good Cause – Section B

▶ Is there good cause not to provide information about the absent parent? ☐ yes ☐ no
(If yes, please fill out Section B. If no, fill out Section C.)

Name(s) of the child or children whose absent parent(s) you do not want to give us information about:	Name(s) of the child or children whose absent parent(s) you do not want to give us information about:
_____	_____
▶ What is the good cause reason not to provide information about absent parent? ☐ Adoption of child in process ☐ Cooperation would result in physical or emotional harm to a child or family member ☐ Child was the result of sexual abuse or assault	▶ What is the good cause reason not to provide information about absent parent? ☐ Adoption of child in process ☐ Cooperation would result in physical or emotional harm to a child or family member ☐ Child was the result of sexual abuse or assault

Absent Parent Information – Section C

Absent parent name	Social security number*	Date of birth / /	Gender ☐ Male ☐ Female
▶ Is the address of this person unknown? ☐ yes ☐ no	▶ Is there a medical support order? ☐ yes ☐ no		
Address of absent parent	Zip code/postal code	Telephone number ( )	
▶ Name of child(ren) of this absent parent?			

Absent parent name	Social security number*	Date of birth / /	Gender ☐ Male ☐ Female
▶ Is the address of this person unknown? ☐ yes ☐ no	▶ Is there a medical support order? ☐ yes ☐ no		
Address of absent parent	Zip code/postal code	Telephone number ( )	
▶ Name of child(ren) of absent parent?			

*Required, if obtainable and one has been issued.

Signature – Section D

I am the parent whom the child lives with (custodial parent) or legal guardian, and I understand that by signing below I am assigning my rights and give permission to MassHealth and DOR to go after medical support from the absent parent of any child under age 19 who is living with me and applying for MassHealth. I also agree to cooperate with MassHealth and DOR in this process, as explained in the Assignment of Rights in Section A.

**Signature of custodial parent or legal guardian:

_____ Date: _____

**Required only if you are applying for yourself and the child who is living with you.

Executive Office of Health and Human Services

MassHealth Virtual Gateway
Personal-Care-Attendant Supplement Form

Please print clearly. Fill out all sections. If you need more space to finish any section on this form, please use a separate sheet of paper, and attach it to this form.

Applicant/Member information

Last name	First name	MI	Telephone number	Social security number	Date of birth	Sex
			( )		/ /	☐ M ☐ F
Street address			City		State	Zip

Information about your health problems

List and describe below all your medical and mental-health problems. Include anything that makes it hard for you to do daily living activities, like bathing, eating, toileting, dressing, etc., even if you are not getting treatment for the problem.

1. _____

2. _____

3. _____

Information about your daily living activities that you need physical (hands on) help with

Please tell us in the chart below if you need hands-on help from another person to do the following daily living activities. If you check "yes" to any of the items below, tell us how often you need help.

Daily living activity	Do you need hands-on help?	How many times a **day** do you need hands-on help?	How many **days a week** do you need hands-on help?
Mobility (moving from bed to chair, walking, or using approved medical equipment)	☐ yes ☐ no		
Taking medications	☐ yes ☐ no		
Bathing (tub, bed bath, shower, or washing chair) or general grooming (like brushing teeth or combing hair)	☐ yes ☐ no		
Dressing/Undressing	☐ yes ☐ no		
Range-of-motion exercises (exercising joints by moving them)	☐ yes ☐ no		
Eating	☐ yes ☐ no		
Toileting (like getting on or off toilet, wiping yourself, getting clothes off and on, or changing diapers)	☐ yes ☐ no		

Caregiver information

Please give us the name(s) and relationship to you of the person(s) who now helps you.	
Caregiver name	Relationship to you (like relative, neighbor, personal-care attendant)
Caregiver name	Relationship to you (like relative, neighbor, personal-care attendant)

I certify, under penalty of perjury, that the information on this form is correct and complete to the best of my knowledge.

If you are acting on behalf of someone in filling out this form, a MassHealth Eligibility Representative Designation Form must also be filled out and sent back with this form. Your signature on this form as an eligibility representative certifies that the information on this form is correct and complete to the best of your knowledge.

X _____ _____

Signature of applicant/member or eligibility representative — Date

Executive Office of Health and Human Services

Common Intake Application for MassHealth and Other Benefits

Head of Household SSN:_____	Head of Household Date of Birth: _____

Signature Page

Please read this page carefully, then sign and date the next page.

I understand that this application permits me to apply for MassHealth, CMSP, Healthy Start, and for low-income patient status with the Uncompensated Care Pool. These programs will be referred to below as EOHHS/applied programs.

I understand that the permissions and certifications I am providing below apply to EOHHS/applied programs and, to the extent applicable, when I apply to other EOHHS agencies and programs through the EOHHS electronic common application.

I certify that I have read or had read to me the information on this application and on any supplements to it, and, if I applied for health-care coverage, the information in the MassHealth Member Booklet or the MassHealth and You Guide, and that I understand my rights and responsibilities.

I give permission for my current and former employers and health insurers to release to EOHHS/applied programs any and all information they have about my health-insurance coverage and health-insurance coverage for members of my family group. This includes, but is not limited to, information about policies, premiums, coinsurance, deductibles, and covered benefits that are, may be, or should have been available to me or members of my family group.

I give permission to EOHHS/applied programs to get any records or data to prove any information given on this application and any supplements to it, or other information I give to EOHHS/applied programs once I am a member. If I or my family is found eligible for MassHealth, CMSP, or Healthy Start, I give permission to MassHealth to get any records about medical services provided through these programs. If I or my family are determined to be low-income patients, I give permission to the Division of Health Care Finance and Policy to get any records about medical services that were provided to me or my family by a health-care provider claiming payments from the Uncompensated Care Pool. I understand that the information I provide in this application will be accessed by EOHHS/applied programs for the purpose of determining eligibility for EOHHS services.

I understand that other EOHHS agencies may use the information I have provided in this application in future applications if I apply for other EOHHS services. To the extent permitted by law, I understand that EOHHS/applied programs (and any future EOHHS programs to which I apply) may share with a hospital, community health center, other medical provider, or the other EOHHS programs to which I apply the status of my application(s) when that is necessary for treatment, payment, operations, or the administration of the program from which I am seeking services.

I understand that if I or any members of my family are in an accident, or are injured in some other way, and get money from a third party because of that accident or injury, we will need to use that money to repay EOHHS/applied programs for certain medical services provided, including those explained in the MassHealth Member Booklet and MassHealth and You Guide. I also understand that I must tell the EOHHS/applied programs that I am receiving services from in writing, within 10 days, if I file any insurance claim or lawsuit because of an accident or injury to me or a family member applying for benefits.

Head of Household SSN:_____	Head of Household Date of Birth: _____

Signature Page (continued)

I understand that if I or any members of my family are eligible for any EOHHS service, I must tell the EOHHS agencies providing services to me or my family of any changes in my or my family's income or employment, family size, assets, health-insurance coverage and health-insurance premiums, immigration, address, or of changes in any other information I gave on this application and any supplements to it within 10 days of learning of the change.

I also understand that by signing below, I give permission to EOHHS/applied programs to go after and collect third-party payments for medical care and medical support from the parent of any child under age 19 who is applying for benefits.

I certify that I have received the following documents as part of my application for MassHealth: MassHealth Member Booklet and MBR, or a MassHealth and You Guide and a Senior Medical Benefit Request, along with information about voter registration, immigration, a Women, Infants, and Children (WIC) Nutrition Program brochure, a Primary Language Identification Form, and a MassHealth Eligibility Representative Designation Form.

If I or any member of my family is eligible for MassHealth, CMSP, or Healthy Start, I understand that I may have to pay a premium set by MassHealth. If I am a certain American Indian or Alaska Native eligible for MassHealth Family Assistance, I may not have to pay any premiums under MassHealth Family Assistance.

I understand that if I am aged 55 or older, that after I die, MassHealth may be able to get back money from my estate.

If you have applied for MassHealth, CMSP, or Healthy Start, and think the decision about whether you are eligible is wrong, you have the right to appeal. If you also have applied for the Uncompensated Care Pool, you have the right to file a grievance. If you are denied benefits, you will get information about how to appeal or file a grievance.

The head of household, all persons aged 18 or older, and all parents of any age who have children living with them who are applying for MassHealth, CMSP, Healthy Start, or the Uncompensated Care Pool, must read this page carefully, and sign and date below. If you are acting on behalf of someone in filling out this application and signing below as an eligibility representative, a filled out Eligibility Representative Designation Form must also be signed and submitted. Your signature on this application as an eligibility representative certifies that the information on this application and any supplements to it is correct and complete to the best of your knowledge.

I certify under the penalty of perjury that the information on this application and any supplements to it is correct and complete to the best of my knowledge.

X _____ _____

Signature of applicant or eligibility representative — Date

X _____ _____

Signature of applicant or eligibility representative — Date

X _____ _____

Signature of applicant or eligibility representative — Date

Executive Office of Health and Human Services
Common Intake Application for MassHealth and Other Benefits
Acceptable Verifications

Verification Item	Acceptable Verification Documents
Self Employment Income	• Signed copy of most recent federal 1040 tax return with relevant attachments • Accounting of business income and expenses for the past 12 months, signed by an accountant (or the applicant, if no accountant) if no federal 1040 tax return form has been filed
Wage Income	• 2 recent pay stubs from the past six months • Letterhead statement of gross monthly or weekly earnings

Income-Other	• All types: most recent federal 1040 tax return with any attachments
	• Child support or alimony: signed statement indicating amount of child support, photocopy of court order, copies of checks, child support verification from DOR
	• Income from investments and trust income: most recent federal 1040 tax return or year-end financial statement
	• Pension or annuities: photocopy of award letter or check stubs or direct-deposit statement
	• Unemployment compensation: copy of check
	• Veterans benefits
	• Workers' compensation: copy of check or benefit award letter
	• Rental income:
	  • for persons under the age of 65: copy of most recent federal 1040 tax return
	  • for persons aged 65 or older who are not required to file annual income tax returns: copy of lease agreement, cancelled check, statement from tenant showing amount of rent paid, mortgage statement showing principal and interest, tax bill, owner's insurance, water, sewage, and bills for repair and maintenance

Disability	• Certificate of legal blindness by the Massachusetts Commission for the Blind • Determination of disability by the MassHealth Disability Determination Unit
Assets	• Annuities: copies of all annuity contracts and statement from the annuity company showing value and costs of converting to a lump sum • Bank accounts: copies of updated bankbooks, bank statements, money market accounts, certificates of deposit, or other financial statements that show a current balance (within 45 days) • Investments: copies of statements from financial institutions verifying current value and copies of stocks, bonds (including savings bonds), mutual funds, promissory notes, certificates, trust funds, and pension and retirement accounts • Life insurance: copies of the first page of all life-insurance policies. If the total value of all policies exceeds $1500, also send a letter from the insurance company showing the current cash-surrender value (except for term life insurance policies). • Burial/funeral plans and accounts: copies of burial/funeral insurance policies, contracts, and accounts • Motor vehicles/mobile homes/boats: title or registration, loan agreements, bill of sale for mobile home/boat • Real estate/property [other than business]: copy of deed, most recent tax bill • Real estate/property [business]: most recent federal 1040 tax return and all attachments
Immigration Status	• Alien registration card (green card-form I-151 or I-551) • Employment authorization card (I-327B) • Foreign passport • Re-entry permit (I-327) • Visas • Documents from U.S. Department of Homeland Security (DHS) • Certification from Office of Civil Rights (OCR) that applicant is a victim of trafficking • Affidavit of an attorney • Order from an immigration judge
HIV Positive Status	• Letter from a doctor, qualifying health clinic lab, or AIDS service provider or organization, indicating applicant's name and HIV status • You may get benefits for up to 60 days while we wait for proof of your HIV-positive status, if you send us proof of your income.